Form Approved
OMB No. 0938-xxxx

MEDICARE DMEPOS COMPETITIVE BIDDING PROGRAM

For CMS Use Only	
Supplier Application No.	Date Application Received
Competitive Bid Area	Counties/Zip Codes

Supplier's Identifying Information

Supplier's Legal Business Name	Primary Supplier's Legal Business Name (if applicable)

FORM B: BIDDING SHEET FOR_____

Individual Form MUST be submitted for each Product Category
Primary Supplier Completes for Network

1) What was the total revenue collected for this product category in this CBA by the supplier or network during the past calendar year? All subsequent questions must be answered for the same calendar year. Estimates are acceptable.

❑ $0–$250,000 ❑ $250,000–$500,000 ❑ $500,000–$750,000 ❑ $750,000–$1 million
❑ $1 million–$3 million ❑ $3 million–$6 million ❑ $6 million–$10 million ❑ More than $10 million

What percentage of the total revenue for this product category was collected from Medicare. Estimates are acceptable.

❑ 0% – 10% ❑ 11% – 20% ❑ 21% – 30% ❑ 31% – 40% ❑ 41% – 50%
❑ 51% – 60% ❑ 61% – 70% ❑ 71% – 80% ❑ 81% – 90% ❑ 91% – 100%

2) What was the total number of customers served in this CBA for this product category by the supplier or network during the past calendar year. Estimates are acceptable.

❑ 0 – 25 ❑ 26 – 50 ❑ 51 – 75 ❑ 76 – 100 ❑ 101 – 300
❑ 301 – 500 ❑ 501 – 750 ❑ 751 – 1000 ❑ More than 1,000

What percentage of the total customers for this product category were Medicare beneficiaries. Estimates are acceptable.

❑ 0% – 10% ❑ 11% – 20% ❑ 21% – 30% ❑ 31% – 40% ❑ 41% – 50%
❑ 51% – 60% ❑ 61% – 70% ❑ 71% – 80% ❑ 81% – 90% ❑ 91% – 100%

3) Indicate the counties in this CBA you currently serve for the product category. (If you do not serve an entire county, please indicate the zip codes you currently do not serve in these counties for this product category.)

_____ _____
_____ _____

What percentage of the total geographic area in these counties are you currently serving Medicare beneficiaries?_____
(If you do not serve the entire county, please indicate the zip codes you currently do not serve in these counties.)

_____ _____
_____ _____

4) Based on our data, the HCPCS codes listed below are the top three codes in terms of volume for this product category. Please list the number of units provided to total customers in this CBA during the last calendar year.

Code	Number of Units Provided
Code	Number of Units Provided
Code	Number of Units Provided

Of these top three HCPCS codes for this product category, what percentage of the units in this CBA were for Medicare beneficiaries. Estimates are acceptable.

❑ 0% – 10% ❑ 11% – 20% ❑ 21% – 30% ❑ 31% – 40% ❑ 41% – 50%
❑ 51% – 60% ❑ 61% – 70% ❑ 71% – 80% ❑ 81% – 90% ❑ 91% – 100%

5a) Indicate for the product category the percentage increase in volume you would be capable of providing that would be applicable for all codes during a 12 month period. (It is not necessary for one supplier to meet 100% of the demand for an area.)_____

5b) If you plan to expand under the Competitive Bid Program, please discuss your expansion plan. Please consider the following when addressing the scope of your expansion plan.

	Current	Expansion Plan
Staff (manpower)	_____	_____
Financing (funding levels)	_____	_____
Facilities (square footage, facility)	_____	_____
Inventory Control (method of tracking inventory)	_____	_____
Distribution Methods (vehicles, mail order)	_____	_____
Other_____	_____	_____

5c) If you plan to expand through the use of subcontractors, to meet the goals of your expansion plan, identify the legal entities with which you anticipate entering into a subcontracting agreement with in order to furnish DMEPOS items if awarded a competitive bid contract. (See subcontracting and program requirements.)

Legal Name	Expected Function	Copies of Letters of Agreement Attached
_____	_____	❑ Yes ❑ No
_____	_____	❑ Yes ❑ No
_____	_____	❑ Yes ❑ No
_____	_____	❑ Yes ❑ No
_____	_____	❑ Yes ❑ No

5d) Please provide copies of signed letters of agreement with each subcontractor noted above that:

- Clearly identifies the parties;
- Describes the functions/services to be performed by the subcontractor;
- Contains language clearly indicating that the subcontractor has agreed to supply items/functions/services;
- Describes the payment the subcontractor will receive;
- Contains anticipated length of agreement;
- Are signed by an authorized official of each party;
- Contain language obligating the subcontractor to abide by State and Federal privacy and security requirements, including the privacy provisions stated in the regulations for this program.

6) Are you a skilled nursing facility, or physician, bidding as a DMEPOS supplier who will only be providing supplies to beneficiaries within your facility? ❑ Yes ❑ No

7) Are you submitting a bid in any other CBA for any other product category? ❑ Yes ❑ No
If yes, please indicate product category/CBA.

Product Category	CBA

8) Optional (additional information):

FORM B: BIDDING SHEET

Supplier's Identifying Information

Supplier's Legal Name (from page 1)	Primary Supplier's Legal Name (if applicable)

C, F and G to be completed by supplier or network primary supplier.

Bid Price MUST include the following:

1. The cost of furnishing the item throughout the geographical area that makes up the CBA;
2. Furnishing the item includes the cost of providing the item and any requisite services associated with the item, such as delivery, retrieval, proper beneficiary and caregiver training, follow-up, manufacturer's shipping charges, maintaining rented equipment in proper working order, education, and set-up;
3. Bid Prices are for new items

A HCPCS Code	B Item Description	C Models to be Provided	D Rental or Purchase	E Product Weight	F Total Estimated Capacity	G Bid Price

To be completed by CBIC.

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